		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005637

Facility Name: St. Joseph Nursing Home

Address: 401 Ninth Street (Number) Lacon (City) 61540 (Zip Code)

County: Marshall

Telephone Number: (309) 246-2175 **Fax #** (309) 246-3609

IDPA ID Number: 0005637

Date of Initial License for Current Owners: 05/07/1965

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Dwayne Richardson **Telephone Number:** (314) 692-5886

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Thomas E. Becker
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Dwayne Richardson, Principal
(Firm Name & Address) CBIZ, Business Solutions of St. Louis, Inc., OneCity Place, Suite 570, St. Louis, MO 63141
(Telephone) (314) 692-5886 Fax # (314) 692-4222

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	93	Intermediate (ICF)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,317	12,183		28,500	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,317	12,183		28,500	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.96%

D. How many bed-hold days during this year were paid by Public Aid?
None. (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None.

F. Does the facility maintain a daily midnight census? Yes.

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/07/1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 07/01/2003 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	308,949		21,874	330,823		330,823	(61,976)	268,847			1
2	Food Purchase		197,166		197,166		197,166	(51,348)	145,818			2
3	Housekeeping	98,040	12,359		110,399		110,399		110,399			3
4	Laundry	71,941		10,000	81,941		81,941		81,941			4
5	Heat and Other Utilities			124,793	124,793		124,793	(4,613)	120,180			5
6	Maintenance	63,931		27,302	91,233		91,233		91,233			6
7	Other (specify):*											7
8	**TOTAL General Services**	542,861	209,525	183,969	936,355		936,355	(117,937)	818,418			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,059,442	66,494	113,710	1,239,646	(1,697)	1,237,949		1,237,949			10
10a	Therapy											10a
11	Activities	63,207	3,687	26,864	93,758		93,758		93,758			11
12	Social Services	64,823	702	14,056	79,581		79,581		79,581			12
13	Nurse Aide Training			1,546	1,546	1,697	3,243		3,243			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,187,472	70,883	156,176	1,414,531		1,414,531		1,414,531			16
	C. General Administration											
17	Administrative	90,250			90,250		90,250		90,250			17
18	Directors Fees											18
19	Professional Services			75,673	75,673		75,673		75,673			19
20	Dues, Fees, Subscriptions & Promotions			15,428	15,428		15,428	(6,087)	9,341			20
21	Clerical & General Office Expenses	95,685	10,345	47,748	153,778		153,778	(5,374)	148,404			21
22	Employee Benefits & Payroll Taxes			388,076	388,076		388,076	(11,721)	376,355			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,066	10,066		10,066		10,066			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,787	69,787		69,787		69,787			26
27	Other (specify):*											27
28	**TOTAL General Administration**	185,935	10,345	606,778	803,058		803,058	(23,182)	779,876			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,916,268	290,753	946,923	3,153,944		3,153,944	(141,119)	3,012,825			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St. Joseph Nursing Home #0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			60,151	60,151		60,151	(8,642)	51,509			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,004	1,004		1,004	(1,004)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			61,155	61,155		61,155	(9,646)	51,509			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,724	2,724		2,724		2,724			39
40	Barber and Beauty Shops		725	13,783	14,508		14,508		14,508			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,058	51,058		51,058		51,058			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		725	67,565	68,290		68,290		68,290			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,916,268	291,478	1,075,643	3,283,389		3,283,389	(150,765)	3,132,624			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,390)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,354)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,273)	30		9
10	Interest and Other Investment Income	(1,004)	32		10
11	Discounts, Allowances, Rebates & Refunds	(198)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(20)	21		16
17	Non-Care Related Fees	(823)	2		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,289)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,798)	20		28
29	Other-Attach Schedule	(116,616)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (150,765)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (150,765)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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St. Joseph Nursing Home

ID# **0005637**

Report Period Beginning: **07/01/2003**

Ending: **6/30/2004**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sisters' Portion of Dietary Costs	$ (61,976)	1	1
2	Sisters' Portion of Food Costs	(36,937)	2	2
3	Sisters' Portion of Heat and Other Utilities	(4,613)	5	3
4	Sisters' Portion of Building Depreciation	(1,369)	30	4
5	Sisters' Portion of Employee Benefits in Meals	(11,721)	22	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(116,616)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Joseph Nursing Home # 0005637 **Report Period Beginning:** 07/01/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(61,976)	0	0	0	0	0	0	0	0	0	0	(61,976)	1
2	Food Purchase	(51,348)	0	0	0	0	0	0	0	0	0	0	(51,348)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,613)	0	0	0	0	0	0	0	0	0	0	(4,613)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(117,937)	0	0	0	0	0	0	0	0	0	0	(117,937)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,087)	0	0	0	0	0	0	0	0	0	0	(6,087)	20
21	Clerical & General Office Expenses	(5,374)	0	0	0	0	0	0	0	0	0	0	(5,374)	21
22	Employee Benefits & Payroll Taxes	(11,721)	0	0	0	0	0	0	0	0	0	0	(11,721)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(23,182)	0	0	0	0	0	0	0	0	0	0	(23,182)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(141,119)	0	0	0	0	0	0	0	0	0	0	(141,119)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Joseph Nursing Home # 0005637 **Report Period Beginning:** 07/01/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,642)	0	0	0	0	0	0	0	0	0	0	(8,642)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,004)	0	0	0	0	0	0	0	0	0	0	(1,004)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,646)	0	0	0	0	0	0	0	0	0	0	(9,646)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(150,765)	0	0	0	0	0	0	0	0	0	0	(150,765)	45

ST. JOSEPH'S NURSING HOME, INC.
SCHEDULE VI, PAGE 5 - ADJUSTMENT DETAIL OF NON-ALLOWABLE EXPENSES
YEAR ENDED JUNE 30, 2004

G/L ACCT #	ACCOUNT DESCRIPTION	SCHEDULE VI DESCRIPTION	Sch VI Line # Ref	Sch VI Per CR 6/30/2004	Sch V Line # Ref	
781029	CAFETERIA REVENUE	NON-PATIENT MEALS	4	$ (13,390)	2.2	
410030	CABLE TV EXPENSE	TELE, TV, AUDIO IN PATIENT ROOMS	5	(5,354)	21.3	
	FROM C/R PAGE 13	NON-STRAIGHT-LINE DEPRECIATION	9	(7,273)	30.3	
801100	INTEREST INCOME (EXPENSE OFFSET)	INTEREST AND OTHER INVESTMENT INCOME	10	(1,004)	32.3	
	DISCOUNTS EARNED	DISCS, ALLOWS, REBATES & REFUNDS	11	(198)	21.3	
	FROM RECLASS & ADJUST WORKSHEET	NON-CARE RELATED OWNER TRANSACTIONS	15	(116,616)	**VARIOUS**	**(SEE SCH V - RECLASSES & ADJUSTMENTS 2004)**
350021	EMPLOYEE PURCHASES	PERSONAL EXPENSES (INCL TRANSPORTATION)	16	(20)	21	
805100	VENDING MACHINES	NON-CARE RELATED FEES	17	(823)	2.2	
410049	ADVERTISING & PUBLIC RELATIONS	FUND RAISING, ADVERTISING & PROMO	25	(6,087)	20.3	***From page 21, Sch F, Non-allowable costs***
		TOTAL NON-ALLOWABLE EXPENSES		**$(150,765)**		

SCHEDULE VI, PAGE 5 - ADJUSTMENT DETAIL OF NON-ALLOWABLE EXPENSES

ST. JOSEPH'S NURSING HOME, INC.
SCHEDULE V, PAGES 3 AND 4 - RECLASSES AND ADJUSTMENTS
YEAR ENDED JUNE 30, 2004

Patient, Sister and Employee Meals:

		Detail	Subtotals	Percentages
Meals served to Patients:	Patient Days (excl. bed-hold days)	28,500		
	Meals per day	3	85,500	81.27%
Meals provided to Sisters:	Number of Sisters	18		
	Meals per day	3		
	Days per year	365	19,710	18.73%
	Total Meals Served		105,210	100.00%

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:	Dietary cost	$ 330,823	*From page 3, Line 1, Col. 4*
	Sisters' percentage	18.73%	*From calculation above*
	Sisters' Portion of Dietary Cost	**$ 61,976**	***Adjustment: To Line 1, Schedule V***
	Food cost	$ 197,166	*From page 3, Line 2, Col. 4*
	Sisters' percentage	18.73%	*From calculation above*
	Sisters' Portion of Food Cost	**$ 36,937**	***Adjustment: To Line 2, Schedule V***
Sisters' portion of building and utilities:			
Sisters' portion of building:	Convent (Sisters) Square Footage	2,464	*From prior year - no changes*
	Total Square Footage	66,656	*From prior year - no changes*
	Convent (Sisters) Offset Percentage	3.70%	
Sisters' portion of utilities:	Heat and Other Utilities	$ 124,793	*From page 3, Line 5, Col. 4*
	Sisters' percentage	3.70%	*From calculation above*
	Sisters' Portion of Heat and Other Utilities	**$ 4,613**	***Adjustment: To Line 5, Schedule V***
Sisters' portion of building depreciation expense:	Building Depreciation Exp	$ 37,025	*From G/L Account No. 782029*
	Sisters' percentage	3.70%	*From calculation above*
	Sister's Portion of Building Depreciation	**$ 1,369**	***Adjustment: To Line 36, Schedule V (also see p 13 of CR)***
Employee Benefits in Sisters' Meals:			
	Dietary Salaries	$ 308,949	*From page 3, Line 1, Col. 1*
	Sisters' percentage	18.73%	*From calculation above*
	Salaries Applicable to Sister's Meals	$ 57,879	
	Total Salaries	$ 1,916,268	*From page 4, Line 45, Col. 1*
	Employee Benefits	$ 388,076	*From page 3, Line 22, Col. 4*
	Employee benefits ratio	20.25%	
	Employee Benefit Adjustment	**$ 11,721**	***Adjustment: To Line 22, Schedule V***
	Total Adjustments for Sisters' Portion of Costs	**$ 116,616**	

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
THIS WORKSHEET IS NOT APPLICABLE.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2	THIS WORKSHEET IS NOT APPLICABLE.										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	THIS WORKSHEET IS NOT APPLICABLE.									3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	NONE.											2
3												3
4												4
5												5
	Working Capital											
6	DAUGHTERS OF ST. FRANCIS OF											6
7	ASSISI (MOTHERHOUSE)	X		WORKING CAPITAL LOC	VARIES	VARIOUS	224,000	183,000	NONE	NONE		7
8	BANK OF LACON		X	WORKING CAPITAL LOC	VARIES	3/16/2004	250,000	60,000	3/16/2005	6.8000	1,004	8
9	TOTAL Facility Related						$ 474,000	$ 243,000			$ 1,004	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 474,000	$ 243,000			$ 1,004	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ NONE	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Joseph Nursing Home COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE (309) 246-2175 FAX #: (309) 246-3609

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	THIS WORKSHEET IS NOT APPLICABLE.		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	OWNED BY DAUGHTERS			$	1
2	OF ST. FRANCIS OF ASSISI	428,532	1965	25,700	2
3	TOTALS	428,532		$ 25,700	3

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1965	1965	$ 484,023	$ 10,533	VARIOUS	$ 7,934	$ (2,599)	$ 480,054	4
5	50		1969	1969	898,293	18,672	VARIOUS	15,650	(3,022)	890,470	5
6			1968	1968	451,401		25			451,401	6
7			1986	1986	3,877		12			3,877	7
8			1987	1987	5,840		15			5,840	8
	Improvement Type**										
9	MISC			1968	6,160		50			6,160	9
10	GARAGE			1972	2,491		50			2,491	10
11	FINISH BASEMENT			1973	6,343		50			6,343	11
12	WINDOW			1974	900		50			900	12
13	INSULATION			1976	21,986		50			21,896	13
14	ROOF			1980	16,049		50			16,049	14
15	MISC REMODELING			1981	7,711		10			7,711	15
16	IDPA AUDIT ADJUSTMENTS			1982	1,290		10			1,290	16
17	IDPA AUDIT ADJUSTMENTS			1983	877		10			877	17
18	IDPA AUDIT ADJUSTMENTS			1984	53,742		VARIOUS			53,742	18
19	IDPA AUDIT ADJUSTMENTS			1985	15,330		15			15,330	19
20	IDPA AUDIT ADJUSTMENTS			1969	28,119		20			28,119	20
21	IDPA AUDIT ADJUSTMENTS			1977	11,869	222	20	222		6,358	21
22	IDPA AUDIT ADJUSTMENTS			1986	94,429	464	VARIOUS	464		94,429	22
23	IDPA AUDIT ADJUSTMENTS			1989	146,038	4,100	VARIOUS	2,771	(1,329)	109,334	23
24	DECORATING			1987	3,285		10			3,285	24
25	PARKING LOT			1988	19,937	39	VARIOUS	39		19,937	25
26	FIRE ALARM SYSTEM			1990	37,956	1,886	VARIOUS	1,886		28,069	26
27	NEW ROOF			1992	55,787		10			55,787	27
28	HOT WATER TANK			1992	3,295		10			3,295	28
29	BUILDING PAINTING			1993	7,336		5			7,336	29
30	ROOF REPAIRS			1993	434		10			434	30
31	WATER HEATER			1993	223	15	15	15		172	31
32	BOILER REPAIR			1993	1,415		10			1,415	32
33	CODE ALERT FIRE SYSTEM			1995	8,559	856	10	856		8,431	33
34	MISC			1997	3,013		10			3,013	34
35	VINYL FLOOR			1998	4,012	403	5	403		4,012	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CERAMIC FLOOR FOR NEW TUB	1999	$ 107	$ 5	20	$ 5	$	$ 28	37
38	CARPET ON WALLS	2000	2,668	534	5	534		2,403	38
39	METAMORA TELEPHONE SYSTEM	2000	7,337	734	10	734		3,303	39
40	TOMKAT ROOFING	2001	18,760	1,876	10	1,876		6,566	40
41	HOBERT CORP	2001	1,555	156	10	156		546	41
42	ASPHALT REPAIR	2002	2,900	363	8	363		907	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,435,347	$ 40,858		$ 33,908	$ (6,950)	$ 2,351,610	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 122,696	$ 10,949	$ 10,626	$ (323)	11	$ 61,747	71
72	Current Year Purchases	24,651	3,560	3,560		4	3,560	72
73	Fully Depreciated Assets	465,884					465,884	73
74								74
75	TOTALS	$ 613,231	$ 14,509	$ 14,186	$ (323)		$ 531,191	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING HOME	CHEVY CAPRICE	1987	$ 10,289	$	$	$		$ 10,289	76
77	NURSING HOME	PICK-UP	1995	14,590					14,590	77
78	NURSING HOME	MISC. OTHER	VARIOUS	5,676					5,676	78
79	NURSING HOME	2001 DODGE RAM 3500 VAN	2002	19,135	4,784	4,784		4	11,960	79
80	TOTALS			$ 49,690	$ 4,784	$ 4,784	$		$ 42,515	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,123,968	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 60,151	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,878	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,273)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,925,316	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SISTERS SHARE OF BUILDING	$ 63,491	$	$ 63,491	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 63,491	$	$ 63,491	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: THIS WORKSHEET IS NOT APPLICABLE.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		376	565		941
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	679	1,018		1,697
6	Transportation					
7	Contractual Payments		242	363		605
8	Nurse Aide Competency Tests					
9	TOTALS		$ 1,297	$ 1,946	$	$ 3,243
10	SUM OF line 9, col. 1 and 2	(e)	$ 3,243			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ NONE.

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs	THIS WORKSHEET IS NOT APPLICABLE.						2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St. Joseph Nursing Home # 0005637 **Report Period Beginning:** 07/01/2003 **Ending:** 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 254,704	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,642)	82,115		3
4	Supply Inventory (priced at Cost)	26,509		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 363,328	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	79,003		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	208,782		15
16	Equipment, at Historical Cost	1,240,919		16
17	Accumulated Depreciation (book methods)	(2,518,948)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Temp. Restr. Assets	260,958		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 813,089	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,176,417	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 61,254	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	60,000		29
30	Accrued Salaries Payable	127,066		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Revenue	60,526		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 308,846	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Motherhouse	183,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 183,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 491,846	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 684,571	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,176,417	$	48

***(See instructions.)**

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 787,582	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 787,582	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(105,204)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Income from Temp Restr Assets**	2,193	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (103,011)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 684,571	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,068,276	1
2	Discounts and Allowances for all Levels	(1,115,763)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,952,513	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	823	12
13	Barber and Beauty Care	19,285	13
14	Non-Patient Meals	13,390	14
15	Telephone, Television and Radio	3,848	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,748	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 39,094	23
	D. Non-Operating Revenue		
24	Contributions	143,138	24
25	Interest and Other Investment Income***	1,014	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 144,152	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Sisters' Maintenance	42,426	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 42,426	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,178,185	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	936,355	31
32	Health Care	1,414,531	32
33	General Administration	803,058	33
	B. Capital Expense		
34	Ownership	61,155	34
	C. Ancillary Expense		
35	Special Cost Centers	17,232	35
36	Provider Participation Fee	51,058	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,283,389	40
41	**Income before Income Taxes (line 30 minus line 40)****	(105,204)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (105,204)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,086	$ 48,141	$ 23.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,800	11,466	219,429	19.14	3
4	Licensed Practical Nurses	7,202	8,664	139,948	16.15	4
5	Nurse Aides & Orderlies	47,761	57,619	496,803	8.62	5
6	Nurse Aide Trainees	4,290	4,733	33,102	6.99	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,998	3,707	55,640	15.01	8
9	Activity Director	576	624	12,168	19.50	9
10	Activity Assistants	5,166	6,002	51,039	8.50	10
11	Social Service Workers	2,595	3,306	36,431	11.02	11
12	Dietician					12
13	Food Service Supervisor	3,552	4,096	58,561	14.30	13
14	Head Cook	8,053	9,066	74,111	8.17	14
15	Cook Helpers/Assistants	7,119	7,710	52,141	6.76	15
16	Dishwashers	14,213	16,336	124,136	7.60	16
17	Maintenance Workers	3,720	4,227	63,931	15.12	17
18	Housekeepers	11,604	13,152	98,040	7.45	18
19	Laundry	8,857	10,051	71,941	7.16	19
20	Administrator	2,000	2,080	85,150	40.94	20
21	Assistant Administrator	40	227	5,100	22.47	21
22	Other Administrative					22
23	Office Manager	1,700	1,737	25,832	14.87	23
24	Clerical	5,334	6,104	69,853	11.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,693	3,094	31,445	10.16	31
32	Other Health Ca MDS Coordinator	1,833	2,068	34,934	16.89	32
33	Other(specify) Social Service Dir	1,204	1,456	28,392	19.50	33
34	TOTAL (lines 1 - 33)	154,182	179,611	$ 1,916,268 *	$ 10.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	171	$ 3,634	1.3	35
36	Medical Director				36
37	Medical Records Consultant	27	1,080	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	1,200	10.3	39
40	Physical Therapy Consultant	83	3,619	10.3	40
41	Occupational Therapy Consultant	16	1,000	10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	45	2,020	10.3	43
44	Activity Consultant	15	903	10.3	44
45	Social Service Consultant	20	1,177	10.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	545	$ 14,633		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas E. Becher	Administrator	0	$ 85,150
Martha Schlink	Asst Administrator	0	5,100
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,250

B. Administrative - Other

Description	Amount
THIS SCHEDULE IS NOT APPLICABLE.	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Achieve Software	Computer Software	$ 6,350
Valuation Counselors	Accounting Services	900
Kronos	Payroll Software	4,019
Mayer Hoffman McCann	Audit Services	8,250
Circle of Quality	Administrative Temp Agency	2,154
Fidelity on Call	Nursing Temp Agency	43,681
Dr. Kaplan, DDS	Dental Services	1,824
Red Wing Business Solutions	Computer Services	584
Life Services Network	Workers' Comp Audit	431
CBIZ Business Solutions	Accounting Services	4,950
Accu-Med Services, Inc.	Computer Services	1,100
Industrial Data Design	Computer Services	1,430
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 75,673

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	8,209
FICA Taxes	137,284
Employee Health Insurance	228,624
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits:	
Other	13,959
Sisters' Maintenance Adjustment	(11,721)
TOTAL (agree to Schedule V, line 22, col.8)	$ 376,355

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
THIS SCHEDULE IS NOT APPLICABLE.		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,523
Health Care Worker Background Check	
(Indicate # of checks performed 45)	540
Misc. Dues and Licenses	5,278
Public Relations	4,289
Yellow Pages Advertising	1,798
Less: Public Relations Expense	(4,289)
Non-allowable advertising	( )
Yellow page advertising	(1,798)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,341

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ None
In-State Travel	1,207
Van Maintenance & Gas	3,360
Seminar Expense	5,499
Entertainment Expense	None
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,066

**See instructions.

ST. JOSEPH NURSING HOME
SCHEDULE XIX, G, PAGE 21 SUPPORT
SCHEDULE OF SEMINAR EXPENSE
Year Ended June 30, 2004

SEMINAR NAME	EMPLOYEE(S)	DATE	COST
Activity Based Alzheimer Care	Anita Evans	September 17, 2003	$ 75
LSN Foundation	Thomas Becher	July 7, 2003	95
Illinois Health Care Association	Richard Dubois	July 7, 2003	165
Illinois Health Care Association	Kim Major Angela Taliani Thomas Becher Paige Whitney Betsy Hill	July 10, 2003	390
Illinois Health Care Association	Thomas Becher Paige Whitney Kim Major Angela Taliani Betsy Hill	August 20, 2003	1,100
LSN Foundation - Leadership in Safety	Thomas Becher Denny Weaver	October 9, 2003	50
Finding Fund Raising Focus	Thomas Becher Kim Major	June 29, 2004	250
Illinois Nursing Home Administrator's Association	Thomas Becher Paige Whitney Kim Major Betsy Hill	June 28, 2004	250
Pressure Ulcer Management	Paige Whitney	June 9, 2004	169
The Role of Social Services in Long-Term Care	Angela Taliani	October 21, 2003	180
Social Service Professional of Illinois	Angela Taliani Harriet Cowell	January 29, 2004	323
Sanitation Class	Joni Hufnagel Deb Hagemeier	November 3, 2003	185
American Dietetic Association	Deb Hagemeier	March 12, 2004	73
Keeping Your Center of Gravity	Kim Major	October 21, 2003	169
Bone & Joint Disease	Kim Major	November 3, 2003	97
Illinois Nursing Home Administrator's Association	Thomas Becher Angela Taliani	October 17, 2003	150
PR Certification Class	Deb Deffenbaugh	July 31, 2003	80
Examination Fee SIU - Nurse Aide	Janice Kjelsrud	September 17, 2003	50
American Red Cross	Training Equip	September 3, 2003	225
Beyond Nursing, The Strategic Plan Caregiving	Paige Whitney	October 17, 2003	525
Nursing Aides	Erin Schwab Nicole Hatton Kathy Manuel	November 6, 2003	120
CNA Testing	Judy Kissee	December 5, 2003	300
CNA Instructor Conference	Judy Kissee	April 9, 2004	70
CPR Instructor	CPR Booklets	April 26, 2004	30
CPR Class	CPR Booklets	May 31, 2004	208
Pressure Ulcer Management	Paige Whitney	June 9, 2004	169
	TOTAL SEMINAR EXPENSE		**$ 5,499**

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3	THIS WORKSHEET IS NOT APPLICABLE.												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St. Joseph Nursing Home # 0005637 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Catholic Health Assoc., AAHSA, Life Services Network, Lacon Chamber of Commerce**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **4**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,799** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,058**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES-Sisters(See Adj)** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **13,390**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Mayer Hoffman McCann, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SJNH
INCONTINENCE DETAIL - G/L ACCOUNT NO. 60005
6/30/2004

Purchases of Incontinence Products 7/1/03-6/30/04:

	Breakout
Molicare Briefs Large	$3,569.85
Trim Line Briefs Large	$5,711.76
Trim Line Briefs Medium	$1,189.95
Button Undergarments	$9,281.61
Molimed Maxi Liner	$475.98
SM/MED Protective Prevail	$3,569.85
Total	**$23,799.00**
GL 600050 TOTAL	**$23,799.00**